



## APPLICATION FOR CERTIFICATE OF NEED

### Long Term Care Facility

1. Name of Facility\_\_\_\_\_
2. Address\_\_\_\_\_
 

Street	City	County	Zip
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3. Person responsible for this project\_\_\_\_\_
 

Telephone \_\_\_\_\_ FAX:\_\_\_\_\_

E-mail:\_\_\_\_\_
4. Type of ownership: Proprietary\_\_\_\_\_ Nonproprietary \_\_\_\_\_
5. Attach a list of names and addresses of all persons holding a ten (10) percent or more interest in the facility.
6. If the facility is incorporated, attach a list indicating name, address and position of each corporate officer.

### DESCRIPTION OF PROJECT

7. Attach a narrative description of the proposed project.
8. For applicable items, indicate anticipated date for:
 

Start of Construction	_____
Completion of Construction	_____
Offering of Services	_____
9. Do you have a long-range development plan? Yes\_\_\_\_ No\_\_\_\_

If yes, attach a copy and include a statement describing the relationship of the proposed project to the long-range plan.

Also attach a statement describing the procedure by which the long-range plan (was) or (is being) developed. Identify the participants.

10. If the proposed project involves a change in beds, specify:

	<u>Present No. of Licensed Beds</u>	<u>No. to be Replaced</u>	<u>No. of New Beds</u>	<u>Total No. in Completed Project</u>
Nursing	_____	_____	_____	_____
Residential	_____	_____	_____	_____
TOTAL	_____	_____	_____	_____

11. If the proposed project involves new construction, renovation or expansion of the facility, fill out Exhibit 1, indicating square footage of the project by functional area. Have you discussed the proposed construction/renovation with the appropriate representative of the Department of Inspections and Appeals?

### **NEED DETERMINATION**

12. In detail, describe the need for the proposed project and the methodology that was utilized.
13. Attach a statement describing what you consider to be the geographical service area for this proposed project. Also attach a statement describing what you identify to be the existing or target patient population for this project in the area described.
14. If the project includes an increase in beds, describe the methodology utilized to arrive at the number of beds to be added.
15. How many licensed nursing beds are certified (or will be) for Medicaid?
16. Attach a table or statement indicating volume of admissions related to the proposed project by patient origin (county of residence) for each of the three (3) most recent years.
17. Does the proposed project conform to the State Bed Need determination?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how many beds remain under the current determination for the county in which the proposed project will be located?

(Contact the Certificate of Need Program, 515-281-4344)

18. Report the dates of your last three inspections by the Department of Inspections and Appeals and state how many deficiencies were cited. Did any deficiencies result in citations? If so, briefly describe.
19. Fill out attached Exhibits 2-A and 2-B, specifying, by level of care and payment source, the following:

Historical utilization statistics for each of the three most recent years and forecasted utilization statistics for each of the three years after the service is offered. Assumptions used in developing the forecast should also be listed and supported.

20. If the proposed project involves replacement of facilities and/or equipment, attach a statement describing the age, condition, life expectancy and intended use or disposition of the facilities and/or equipment being replaced.
21. On an attachment, list the names and addresses of other affected or potentially affected providers of the service, similar to the one for which you are seeking approval and serving the patient population(s) identified in #11. For each of these providers, specify the following data and describe your efforts to obtain it. (Attach a copy of the letter of request for information):
  - A. Relevant historical utilization data for each of the three most recent years; and
  - B. Relevant expected utilization data for each of the three years following initiation of the proposed service.
22. Attach a statement describing what arrangements between your facility and other health care facilities have been made or proposed to refer patients, share services, and coordinate programs related to the proposed project.

### **PERSONNEL**

23. If additional personnel will be needed as a result of the proposed project, attach a statement describing either what evidence there is that these personnel will be available, or the plans your facility has for recruiting and employing them. Specify your existing and forecasted full-time equivalents (FTEs):

<u>Department</u>	<u>Current</u>	<u>Forecasted</u>
Administrative	_____	_____
Nursing: RN	_____	_____
LPN	_____	_____
Aides	_____	_____
Dietary	_____	_____
Housekeeping	_____	_____
Laundry	_____	_____
Maintenance	_____	_____

Activities	_____	_____
Other (specify)	_____	_____
<b>TOTAL FTE'S</b>	_____	_____

### **FINANCIAL FEASIBILITY**

24. List the daily rates presently charged and the proposed rates when service is offered.

<u>Level of Care</u>	<u>Present Rate</u>	<u>Proposed Rate</u>
Nursing	_____	_____
Residential	_____	_____

25. Attach a statement indicating present and/or proposed charges for "add-ons" or miscellaneous. Attach a list specifying items and costs.
26. Fill out Exhibit 3, specifying estimated project costs and estimated depreciation. If the assets included in a line-item category are depreciated by differing lives, provide a footnote explanation of the useful lives being used.
27. What is the average cost per bed (turn key basis)? \$\_\_\_\_\_
- (Total Project Costs / Number of Increased Beds)
28. Indicate the source of funds for the project costs.  
(Attach a description of asterisked items.)

<u>SOURCE OF FUNDS</u>	<u>Estimated Amount</u>
Cash on Hand	\$_____
Borrowing*	_____
Gifts and Contributions	_____
Lease	_____
Federal Funds*	_____
State Funds*	_____
Other*	_____
Total Source of Funds	\$_____

To support the debt portion, attach a letter from the lender or financial institution indicating the probable terms of the borrowing or from the underwriters or the bond financial consultants indicating the probable terms of the bond indenture.

29. Attach a statement listing new equipment (if any) for the proposed project and the manner of acquisition (purchase, lease etc.).
30. Attach a schedule of leases, if any, associated with the proposed project. Indicate the type of equipment, term of lease, yearly lease payment any prepayments, and if the lease is renewable or if there is a purchase option.

31. Attach a description of existing debt. This description should include:

A. Terms of Debt

1. Face Amount
2. Interest
3. Payment period
4. Restrictions on additional debt
5. Prepayment
6. Other restrictions or requirements

- B. Is the existing debt going to be refinanced? Yes\_\_\_\_\_ No\_\_\_\_\_
- Is debt incurred to meet project costs going to be refinanced?
- Yes\_\_\_\_\_ No\_\_\_\_\_ For Yes, attach statement describing:

1. Amount to be refinanced; and
2. Terms of refinancing.

- C. Attach annual debt service schedules for: 1) debt incurred to meet project costs: and 2) any debt existing at completion of the proposed project. Use the following format:

<u>Year</u>	<u>Principal</u>	<u>Interest</u>	<u>Annual Debt Service</u>
1st payment			
to			
final payment			

32. Attach audited financial statements and notes to the financial statements for the most recent three years.

33. Will there be an operating deficit as a result of the project?

Yes\_\_\_\_\_ No\_\_\_\_\_ If Yes,

First Year	\$_____
Second Year	\$_____
Third Year	\$_____

Break even point in time, if any

(if later than three (3) years)\_\_\_\_\_

34. Attach a statement describing how your facility has allowed for start-up funds.
35. On an attachment, provide a forecast of revenues and expenses for each year of the first three years after the service is offered. Include a list of assumptions used in the forecasts and support for the assumptions.

### **OTHER CRITERIA**

36. Attach a statement describing how the proposed project will contribute to meeting the needs of the medically underserved, including persons in rural areas, low-income persons, racial and ethnic minorities, handicapped and the elderly.
37. Attach a statement describing what potentially less costly or more appropriate alternatives to the proposed project including but not limited to staffing, scheduling, design service sharing, etc. were considered and rejected. Specify the reasons therefor.
38. Attach a statement describing what impact the proposed project will have on-the distance, convenience, cost of transportation, and accessibility to health services for persons who live outside metropolitan areas.

### **CERTIFICATION**

I, the undersigned, certify that:

I have read chapter 135.61-83, Code of Iowa and the Administrative Rules (IAC 641-2d2 and 203) promulgated pursuant thereto, and

I have read this application, including all exhibits and attachments, and the information therein is, to the best of my knowledge and belief, accurate and true.

\_\_\_\_\_  
Signature of Owner or  
Chairperson, Board of Directors

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Position or Title

\_\_\_\_\_  
Date

If you wish to designate an official representative to act on your behalf, as addressee for written notifications and to speak for you before the Health Facilities Council, specify below:

Name:\_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_



**Exhibit 2-A**  
**Facility Utilization - Historical**

	Year 20____			Year 20____			Year 20____		
	Pri.	St.	Total	Pri.	St.	Total	Pri.	St.	Total
Nursing									
Number of Beds			___			___			___
Patient Days	___	___	___	___	___	___	___	___	___
Percent Occupancy	___	___	___	___	___	___	___	___	___
RCF									
Number of Beds			___			___			___
Patient Days	___	___	___	___	___	___	___	___	___
Percent Occupancy	___	___	___	___	___	___	___	___	___

**Exhibit 2-B**  
**Facility Utilization – Forecasted**

	Year 20____			Year 20____			Year 20____		
	Pri.	St.	Total	Pri.	St.	Total	Pri.	St.	Total
Nursing									
Number of Beds			___			___			___
Patient Days	___	___	___	___	___	___	___	___	___
Percent Occupancy	___	___	___	___	___	___	___	___	___
RCF									
Number of Beds			___			___			___
Patient Days	___	___	___	___	___	___	___	___	___
Percent Occupancy	___	___	___	___	___	___	___	___	___

Pri. = Private Pay Residents

St. = State Assisted Residents

### Exhibit 3

#### Estimate Application of Funds and Estimated Depreciation

	Estimated <u>Amount</u>	<u>First Year</u> Estimated Average Useful Life	<u>(12 Months)</u> Estimated First Year Deprec.
<u>Application of Funds</u>			
Site Costs:			
Site Acquisition	\$ _____		
Demolition of Existing Structures	\$ _____		
Site Preparation	\$ _____		
Other (Specify)	\$ _____		
Subtotal \$	\$ _____		
Land Improvements (Specify) \$	\$ _____		
Facility Costs:			
General (Construction Shell)	\$ _____	_____	_____
Heating, Ventilating, A/C	\$ _____	_____	_____
Plumbing	\$ _____	_____	_____
Electrical	\$ _____	_____	_____
Elevator	\$ _____	_____	_____
Other Fixed Equipment	\$ _____	_____	_____
Architectural	\$ _____	_____	_____
Construction Management, Supervision, Engineering, Testing, Inspection	\$ _____	_____	_____
Other (Specify)	\$ _____	_____	_____
Subtotal	\$ _____	_____	_____
Movable Equipment	\$ _____	_____	_____
Financing Costs:			
Underwriters' Discount	\$ _____		
Pricing Discount	\$ _____		
Feasibility, Legal, Printing & Other	\$ _____		
Interest Expense			
During Construction	\$ _____		
Less Interest Earned			
During Construction	\$ _____		
Other (Specify)	\$ _____		
Subtotal	\$ _____		
Total Project Costs	\$ _____		
Other Applications:			
Debt Service Reserve Account	\$ _____		
Other (Specify)	\$ _____		
Subtotal	\$ _____		
Total Application of Funds	\$ _____		